

PEPFAR: Policy Issues from FY2004 through FY2008

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Summary

The Joint United Nations Program on HIV/AIDS (UNAIDS) estimates that 33.2 million people are living with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). The U.N. organization believes that in 2007, some 2.5 million people will contract HIV and it will kill about 2.1 million. Sub-Saharan Africa is the most affected region, with about 68% of the world's HIV-positive population, 90% of all HIV-infected children, and more than 11 million children who have lost one or both parents to the virus. UNAIDS anticipates that in 2007, about 420,000 children will contract HIV, due in large part to inadequate access to drugs that prevent mother-to-child HIV transmission; about 8% of pregnant women in low- and middle-income countries have access to PMTCT services.

In January 2003, President George Bush proposed that the United States spend \$15 billion over five years to combat HIV/AIDS, tuberculosis (TB), and malaria through the President's Emergency Plan for AIDS Relief (PEPFAR). The President proposed concentrating most of the resources (\$9 billion) in 15 countries, where the Administration estimated 50% of all HIV-positive people lived. The proposal allotted \$5 billion of the funds to research and other bilateral HIV/AIDS, TB, and malaria programs, and \$1 billion for contributions to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund). The President estimated that from FY2004 to FY2008, PEPFAR funds would support the purchase of anti-retroviral treatments (ARV) for 2 million people; the prevention of 7 million HIV infections; and care for 10 million people affected by HIV/AIDS, including children orphaned by AIDS.

In May 2003, Congress passed the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L. 108-25), which authorized funds for PEPFAR and created the Office of the Global AIDS Coordinator (OGAC) to manage U.S. funds aimed at addressing the three diseases in 15 Focus Countries. As of March 31, 2007, PEPFAR has supported the treatment of 1.1 million people; and as of September 30, 2006, supported PMTCT service provision during more than 6 million pregnancies and facilitated care for nearly 4.5 million people, including more than 2 million orphans and vulnerable children. From FY2004 to FY2007, Congress provided nearly \$13.5 billion for U.S. global HIV/AIDS, TB, and malaria programs. In FY2008, the President requested \$5.8 billion for global HIV/AIDS, TB, and malaria efforts; the House and Senate proposed spending almost \$6.2 billion and nearly \$6.1 billion, respectively.

On May 30, 2007, President Bush requested that Congress authorize \$30 billion to fund PEPFAR an additional five years. The President asserts that from FY2009 to FY2013, the plan would support treatment for 2.5 million people, prevent more than 12 million new infections, and care for more than 12 million people, including 5 million orphans and vulnerable children. Supporters of the Administration's plan applauded the President and congratulated him for leading global efforts to address HIV/AIDS. Critics asserted that PEPFAR could treat more than 2.5 million HIV-infected people and that PEPFAR's spending requirements should be eliminated. This report focuses on some of the key issues that Congress might consider as it faces the issue of whether, and at what level, to reauthorize PEPFAR.

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Background

HIV/AIDS

Revised Epidemic Estimates

The Joint United Nations Program on HIV/AIDS (UNAIDS) estimates that 33.2 million people are living with human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/AIDS); some 16% fewer people than it initially estimated in 2006 (about 39.5 million). UNAIDS asserts that the decline reflects improvements in data collection and analysis. Expanded and improved HIV surveillance systems and household surveys reportedly provided a more precise count of HIV prevalence than earlier studies.¹ In most of the 30 countries where household studies were conducted, prevalence rates in 2007 were lower than those reported in 2006 (**Table 1**).

UNAIDS also used the expanded studies to adjust prevalence estimates of countries that had not conducted household surveys but had similar epidemics. After retrospectively applying the improved methodology, UNAIDS estimated that in 2006, 32.7 million people were living with HIV (adjusted from the original estimate of 39.5 million). The revised estimates for India (2.5 million, down from 5.7 million), combined with revisions in five sub-Saharan African countries (Angola, Kenya, Mozambique, Nigeria, and Zimbabwe) accounted for 70% of the reduction.²

2007 Estimates

UNAIDS notes that HIV/AIDS prevalence rates have largely stabilized since 2001 and HIV/AIDS incidence rates are mostly declining (**see Table 2**).³ Although prevalence rates have stabilized and incidence rates are mostly declining, the total number of people living with HIV/AIDS continue to rise, though at a slower rate. UNAIDS predicts that 2.5 million people will contract HIV in 2007, compared to the estimated 3.2 million who became HIV-positive in 2001. UNAIDS does not expect the number of HIV/AIDS-related deaths to decrease, however; in 2007, some 2.1 are expected to die from AIDS, while 1.7 million died in 2001.

¹ For example, in India, the number of sentinel surveillance sites increased to more than 1,100 in 2006 (up from 155 in 1998) and now more extensively cover at-risk populations. Since 2001, 30 countries in sub-Saharan Africa, Asia, and the Caribbean have conducted national population-based surveys. Results from such population-based surveys have generally indicated lower national HIV prevalence than extrapolations from sentinel site surveillance. For more information on this process, see UNAIDS, *2007 AIDS Epidemic Update*. http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf.

² For 2006 estimates, see UNAIDS, *2006 Report on the Global AIDS Epidemic*, http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.

³ *Prevalence* is the total number of cases within a given time period; *incidence* is the number of new cases within a given time period, such as a year.

Table I. Adult (15-49 years) HIV Prevalence in Countries That Have Conducted Population-Based HIV Surveys Since 2001

Countries	Population-Based Survey HIV Prevalence Rate (%)	Year Population-Based Survey Conducted	2001 Prevalence (%) Reported in 2002 AIDS Epidemic Report	2003 Prevalence (%) Reported in 2004 AIDS Epidemic Report	2005 Prevalence (%) Reported in 2006 AIDS Epidemic Report
Sub-Saharan Africa					
Benin	1.2	2006	3.6	1.9	1.8
Botswana	25.2	2004	38.8	38.0	24.1
Burkina Faso	1.8	2003	6.5	4.2	2.0
Burundi	3.6	2002	8.3	6.0	3.3
Cameroon	5.5	2004	11.8	7.0	5.4
Central African Rep.	6.2	2006	12.9	13.5	10.7
Chad	3.3	2005	3.6	4.8	3.5
Cote d'Ivoire	4.7	2005	9.7	7.0	7.1
Equatorial Guinea	3.2	2004	3.4	Not Available	3.2
Ethiopia	1.4	2005	6.4	4.4	0.9 - 3.5
Ghana	2.2	2003	3.0	3.1	2.3
Guinea	1.5	2005	Not Available	2.8	1.5
Kenya	6.7	2003	15.0	6.7	6.1
Lesotho	23.5	2004	31.0	29.3	23.2
Malawi	11.8	2004	15.0	14.2	14.1
Mali	1.3	2006	1.7	1.9	1.7
Niger	0.7	2006	Not Available	1.2	1.1
Rwanda	3.0	2005	8.9	5.1	3.1
Senegal	0.7	2005	0.5	0.8	0.9
Sierra Leone	1.5	2005	7.0	Not Available	1.6
South Africa	16.2	2005	20.1	20.9	18.8
Swaziland	25.9	2006-2007	33.4	38.8	33.4
Uganda	7.1	2004-2005	5.0	4.1	6.7
Tanzania	7.0	2004	7.8	9.0	6.5
Zambia	15.6	2001-2002	21.5	16.5	17.0
Zimbabwe	18.1	2005-2006	33.7	24.6	20.1

Countries	Population-Based Survey HIV Prevalence Rate (%)	Year Population-Based Survey Conducted	2001 Prevalence (%) Reported in 2002 AIDS Epidemic Report	2003 Prevalence (%) Reported in 2004 AIDS Epidemic Report	2005 Prevalence (%) Reported in 2006 AIDS Epidemic Report
Asia					
Cambodia	0.6	2005	2.7	2.6	1.6
India	0.28	2005-2006	0.8	0.9	0.9
Latin America and Caribbean					
Dominican Republic	1.0	2002	2.5	1.7	1.1
Haiti	2.2	2005-2006	6.1	5.6	3.8

Source: UNAIDS, 2007 AIDS Epidemic Update

Table 2. Regional HIV/AIDS Statistics, 2001 and 2007

	Adults and Children Living with HIV (thousands)		Adults and Children Newly Infected with HIV (thousands)		Adult Prevalence (%)		Adult and Child Deaths Due to AIDS (thousands)	
	2001	2007	2001	2007	2001	2007	2001	2007
Sub-Saharan Africa	20,900	22,500	2,200	1,700	5.8	5.0	1,400	1,600
South & Southeast Asia	3,500	4,000	450	340	0.3	0.3	170	270
Latin America	1,300	1,600	130	100	0.4	0.5	51	58
North America	1,100	1,300	44	46	0.6	0.6	21	21
E. Europe & Central Asia	630	1,600	230	150	0.4	0.9	8	55
Western & Central Europe	620	760	32	31	0.2	0.3	10	12
East Asia	420	800	77	92	<0.1	0.1	12	32
Middle East & N. Africa	300	380	41	35	0.3	0.3	22	25
Caribbean	190	230	20	17	1.0	1.0	14	11
Oceania	26	75	3.8	14	0.2	0.4	<0.5	1.2
Total	29,000	33,200	3,200	2,500	0.8	0.8	1,700	2,100

Source: UNAIDS, 2007 AIDS Epidemic Update.

Tuberculosis

HIV/AIDS is contributing to rising TB prevalence in areas with high HIV/AIDS prevalence, particularly in Africa.⁴ The weakened immune systems of HIV-positive people places them at greater risk of contracting TB. Correspondingly, TB considerably shortens the survival of people with HIV/AIDS. In 2005, about 80% of all HIV-positive people with TB were found in Africa. That year, nearly 630,000 people were co-infected with HIV/AIDS and TB, some 500,000 of whom were African. About 160,000 of the nearly 195,000 co-infected patients who died from TB were African, representing 82% of those deaths.

Although most forms of TB are curable, the World Health Organization (WHO) estimates that in 2005 (the year for which the most current data are available), the disease killed 1.6 million people, including 195,000 who were also infected with HIV/AIDS.⁵ Some 8.8 million people contracted the disease in 2005, of which 84% of the cases occurred in 22 countries.⁶ All but three of those high-burden countries were found in Africa or Asia. About half of all new TB cases were in six countries: Bangladesh, China, India, Indonesia, Pakistan, and the Philippines.

Malaria

While HIV/AIDS, TB, and malaria are preventable diseases, their impacts have been catastrophic, particularly in sub-Saharan Africa. Researchers have found that people infected with one of the three illnesses are more likely to contract either of the other two, and the symptoms are more severe in people with two or more of the diseases. According to WHO, each year there are about 300 million acute malaria cases,⁷ which cause more than 1 million deaths annually. Health experts believe that between 85% and 90% of malaria deaths occur in Africa, mostly among children,⁸ killing an African child every 30 seconds.⁹

Global Spending on HIV/AIDS

UNAIDS asserts that it would cost \$15 billion in 2006, \$18 billion in 2007, and \$22 billion in 2008 to effectively fight HIV/AIDS.¹⁰ In FY2006, Congress provided \$3.4 billion for global

⁴ Information in this paragraph was summarized from WHO, *Frequently asked questions about TB and HIV/AIDS*. <http://www.who.int/tb/HIV/AIDS/faq/en/index.htm>. For more information on the impacts of TB and HIV/AIDS co-infection see CRS Report RL34246, *Tuberculosis: International Efforts and Issues for Congress*, by Tiaji Salaam-Blyther.

⁵ WHO Report 2006, *Global Tuberculosis Control: Surveillance, Planning, Financing*, at http://www.who.int/tb/publications/global_report/en/index.html. For more information on TB, see CRS Report RL34246, *Tuberculosis: International Efforts and Issues for Congress*, by Tiaji Salaam-Blyther.

⁶ The 22 high-burden countries were: Afghanistan, Bangladesh, Brazil, Burma, Cambodia, China, Democratic Republic of Congo, Ethiopia, India, Indonesia, Kenya, Mozambique, Nigeria, Pakistan, Philippines, Russia, South Africa, Tanzania, Thailand, Uganda, Vietnam, and Zimbabwe.

⁷ There are four types of malaria: *Plasmodium (P.) vivax*, *P. malaria*, *P. ovale*, and *P. falciparum*. *P. falciparum*, the deadliest kind, is most common in sub-Saharan Africa and is a significant factor in the region's high malarial mortality rate. People contract malaria from infected mosquitos; and mosquitos can get malaria if they ingest blood from an infected person. http://malaria.who.int/cmc_upload/0/000/015/372/RBMInfosheet_1.htm.

⁸ WHO estimates that annually, 300 million malaria cases cause 1 million deaths with 90% of the deaths in sub-Saharan Africa. The World Bank believes average annual cases exceed 500 million and about 85% of malarial deaths are in sub-Saharan Africa, 8% in southeast Asia, 5% in the Middle East, 1% in the Western Pacific, and 0.1% in the Americas.

⁹ WHO's Roll Back Malaria website, http://malaria.who.int/cmc_upload/0/000/015/372/RBMInfosheet_1.htm.

¹⁰ UNAIDS, *Towards Universal Access: Assessment by the Joint United Nations Program on HIV/AIDS on Scaling Up HIV Prevention, Treatment, Care and Support*, March 2006. <http://data.unaids.org/pub/InformationNote/2006/>

HIV/AIDS, tuberculosis (TB), and malaria programs (**Table 3**). Most recent statistics indicate that in 2006, global spending reached nearly \$9 billion, \$6 billion less than UNAIDS advocated.¹¹

Table 3. U.S. Global HIV/AIDS, TB, and Malaria Appropriations

(\$U.S. current, millions)

PROGRAM	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 CR	FY2008			
					Request	House	Senate	Enacted
1. USAID HIV/AIDS (excluding Global Fund)	549.2	382.8	373.8	464.5	346.3	382.0	350.0	NYE
2. USAID Tuberculosis	100.4	87.8	91.5		89.9	313.5 ^a	200.0	NYE
3. USAID Malaria ^b	100.9	98.2	102.0	248.0	387.5	352.5	357.5	NYE
4. USAID Global Fund Contribution	397.6	247.9	247.5	247.5	0.0	250.0	250.0	NYE
5. FY2004 Global Fund Carryover ^c	-87.8	87.8	n/a	n/a	n/a	n/a	n/a	NYE
6. State Department GHA1	488.1	1,373.5	1775.1	2,869.0	4,150.0	4,150.0	4,150.0	NYE
7. GHA1 Global Fund Contribution	0.0	0.0	198.0	377.5	0.0	300.0	340.0	NYE
8. Foreign Military Financing ^d	1.5	1.9	1.9	—	0.0	0.0	0.0	NYE
9. Subtotal, Foreign Operations Appropriations	1549.9	2279.9	2,789.8	4,206.5	4,973.7	5,748.0	5,647.5	
10. CDC Global AIDS Program ^e	291.8	123.8	122.7	120.8	121.2	122.7	122.7	NYE
11. NIH International Research ^f	317.2	370.0	373.0	372.0	373.0	—	—	NYE
12. NIH Global Fund contribution	149.1	99.2	99.0	99.0	300.0	300.0	300.0	NYE
13. DOL AIDS in the Workplace Initiative	9.9	1.9	0.0	—	0.0	0.0	0.0	NYE
14. Subtotal, Labor/HHS Appropriations	768.0	594.9	594.7	591.8	794.2	—	—	
15. DOD HIV/AIDS prevention education	4.2	7.5	5.2	—	0.0	10.0	—	8.0

20060324_hlm_ga_a60737_en.pdf.

¹¹ *Financing the Response to AIDS in Low- and Middle- Income Countries: International Assistance from the G8, European Commission and Other Donor Governments*, Kaiser Family Foundation, 2006, http://www.kff.org/hivaids/upload/7347_03.pdf.

PROGRAM	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 CR	FY2008			
					Request	House	Senate	Enacted
16. Section 416(b) Food Aid	24.8	24.8	24.8	—	0.0	—	—	NYE
17. TOTAL	2346.9	2907.1	3,414.5	4,798.3	5,767.9	—	—	

Sources: Prepared by CRS from appropriations legislation figures and interviews with Administration staff.

Note: This chart does not include discretionary spending on global HIV/AIDS, TB, and malaria programs, such as CDC's international HIV research and its global TB and malaria initiatives. "—" indicates that funds were not earmarked, but could be provided at the Administration's discretion. "NYE" means that the bill has not yet been enacted.

- a. Includes \$150.0 million provided to the Global HIV/AIDS Initiative for global TB efforts.
- b. House and Senate appropriations committees began reporting out global malaria funds separately from those supporting global HIV/AIDS and TB initiatives after President Bush launched the President's Malaria Initiative (PMI) in June 2005. The Administration reports that PMI became operational in FY2006 though Congress first appropriated funds to PMI in FY2007. That fiscal year, Congress provided \$248.0 million for international malaria programs, including \$149.0 million to expand PMI.
- c. In FY2004, Congress withheld \$87.8 million of the U.S. contribution to the Global Fund, because legislative provisions prohibit U.S. contributions from exceeding 33% of all donor contributions to the Fund. FY2005 Consolidated Appropriations restored the funds.
- d. Foreign Military Financing funds are used to purchase equipment for DOD HIV/AIDS programs (Line 15).
- e. In FY2004, the International Mother and Child HIV Prevention Initiative expired. In subsequent fiscal years, Congress appropriated funds for PMTCT activities to the Global HIV/AIDS Initiative account, though CDC continues related efforts.
- f. The figures used in Line 11 reflect the amount the Office of AIDS Research (OAR) reports it spends on international HIV/AIDS research. Congress does not specify how much the Office should spend on this effort.

Policy Options for Congress

In 2003, Congress authorized \$3 billion for each fiscal year from 2004 through 2008 to support the President's Emergency Plan for AIDS Relief (PEPFAR). The 5-year initiative was created to aid the millions of people sickened and killed by HIV/AIDS, malaria, and tuberculosis (TB). Some estimate that since HIV/AIDS was first identified in 1981, 65 million people have contracted the virus and it has killed more than 25 million.¹²

PEPFAR provided an unprecedented amount of assistance for global HIV/AIDS efforts. The United States remains the largest single donor for global HIV/AIDS efforts in the world, providing nearly 50% of all donor funds.¹³ As Congress prepares to consider whether, and at what level, to reauthorize PEPFAR, there has been considerable debate about the effectiveness of PEPFAR. Some health experts contend that the life-saving intention of PEPFAR is weakened by the single-disease approach. Other critics contend that ideological factors lessen the effectiveness of the plan. A number of HIV/AIDS advocates urge the United States to harmonize its anti-HIV/AIDS efforts with other donors to boost the impact of PEPFAR. Some of the key policy prescriptions are discussed below.

¹² Avert, an international HIV/AIDS charity, used UNAIDS data to reach its estimate. See world AIDS statistics at <http://www.avert.org/worldstats.htm>.

¹³ Ibid.

Define Focus of PEPFAR

As Congress considers reauthorizing PEPFAR, there may be some debate on how many diseases the initiative should address. The U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L. 108-25), requires the President to submit annual reports to appropriation committees that describe how U.S. funds support efforts to prevent HIV/AIDS, TB, and malaria and provide care and treatment for those affected by the three diseases. However, since President Bush launched the President's Malaria Initiative (PMI) in June 2005, the Office of the Global AIDS Coordinator (OGAC) determined that it would no longer include malaria spending in its annual reports to Congress and that budgetary requests for the disease would be made separately from HIV/AIDS and TB requests.¹⁴ The Administration requests support for PMI through the U.S. Agency for International Development (USAID) as the coordinating agency. For comparability, and because P.L. 108-25 considers efforts to combat malaria as a critical part of PEPFAR, **Table 3** includes appropriations to malaria programs. As Congress considers whether to authorize funds to extend PEPFAR, Members might decide whether to define it as solely an HIV/AIDS initiative or one that includes the three diseases.

Revisit Prevention Efforts

As Congress considers reauthorizing PEPFAR, there is likely to be considerable debate on how much funding to allocate to prevention. Consensus is growing among health experts that greater emphasis needs to be placed on HIV prevention in global HIV/AIDS programs. The international community has supported a tremendous increase in the number of people receiving HIV/AIDS treatment. In 2001, about 240,000 people had access to anti-retroviral treatment (ARVs); in 2006, more than 2 million were treated.¹⁵ Nonetheless, WHO estimated that in 2006, an additional 5.1 million people who needed treatment received none. In sub-Saharan Africa, more than 1.3 million people received treatment, reaching some 28% of those in need; three years prior, 100,000 were treated and coverage amounted to 2%. In spite of these advances, the rate at which individuals become infected with HIV far outpaces the rate at which they are treated. In 2006, 4.3 million people contracted HIV, 2.8 million of whom were African (65%), and 2.9 million people died of AIDS, 2.1 million of whom were African (72%).

Increase Prevention of Mother to Child HIV Transmission (PMTCT)

Initiatives

Many health experts advocate greater spending on PMTCT initiatives.¹⁶ Advocates of greater PMTCT spending argue that providing ARVs during pregnancy is a well-documented way to

¹⁴ PMI aims to increase U.S. support for global malaria programs by more than \$1.2 billion between FY2006 and FY2010 in 15 countries. For more information on PMI, see <http://www.pmi.gov/>.

¹⁵ Statistics on access to AIDS treatment was compiled from UNAIDS, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, April 2007.

http://www.who.int/hiv/mediacentre/universal_access_progress_report_en.pdf.

¹⁶ Most children living with HIV acquire the disease through mother-to-child transmission (MTCT), which can occur during pregnancy, labor and delivery, or breastfeeding. In the absence of any intervention, the risk of such transmission is 15%-30% in non-breastfeeding populations. Breastfeeding by an infected mother can increase the risk to 45%. The risk of MTCT can be reduced to under 2% by interventions that include the provision of ARV treatments. Elective caesarean delivery and complete avoidance of breastfeeding can also reduce the risk of HIV transmission. In many resource-constrained settings, elective caesarean delivery is seldom feasible, and mothers often lack access to enough clean water or formula to refrain from breastfeeding. Research is ongoing to evaluate several new approaches to

avert millions of HIV infections in a cost-efficient and effective manner, including in low-resource settings. UNAIDS estimates that 1,800 children worldwide become infected with HIV each day, the vast majority of whom are newborns.¹⁷ More than 85% of children infected with HIV live in sub-Saharan Africa, although mother-to-child transmission (MTCT) rates are rapidly rising in Eastern Europe and Central Asia.¹⁸ UNAIDS estimates that in 2005, just less than 8% of pregnant women in low- and middle-income countries had access to services that could prevent the transmission of HIV to their babies.¹⁹ Two-thirds of all women who lack access to PMTCT interventions come from 10 countries, all but one of which are in Africa; India is the exception.²⁰

Provide Contraceptives to HIV-Positive Women

Some reproductive health experts want HIV/AIDS and family planning services to be better integrated should PEPFAR be reauthorized. Supporters of this idea contend that women who receive PMTCT services should be subsequently offered contraceptives to lessen the likelihood that they might give birth to HIV-positive children. Additionally, women who fear being stigmatized if they visit an HIV center could receive PMTCT services while receiving standard prenatal care. Members who endorsed the Ensuring Access to Contraceptives Act (H.R. 2367) demonstrated their support for expanding access to family planning and contraceptives. The bill would authorize \$150 million for such services in each of fiscal years 2008 and 2009. Some in Congress also support the United Nations Population Fund Women's Health and Dignity Act (H.R. 2604), which would provide financial and other support to UNFPA's activities that save women's lives, limit the incidence of abortion and maternal mortality associated with unsafe abortion, promote universal access to safe and reliable family planning, and assist women, children, and men in developing countries live better lives.

Address Gender Inequities

Women's rights advocates also assert that the lower status of women in many of the most affected countries must be better addressed in order to prevent new HIV infections. In many countries, legal and social structures leave women feeling as though they have little control over their own bodies and do not have the option to reject their husbands' sexual advances; even when they are aware of their husbands' extramarital relationships. Research has shown that in Africa, married girls and women are more likely to contract HIV than their single counterparts.²¹ For example, 30% of married adolescents' spouses were HIV-positive in Kenya, while 11.5% of the partners of their unmarried counterparts were infected with HIV. Similarly, in Zambia, 31.6% of married

preventing HIV transmission during breastfeeding.

¹⁷ UNAIDS 2006 Global AIDS Report, p. 132, http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.

¹⁸ UNAIDS 2006 Global AIDS Report, p. 132.

¹⁹ Ibid., p. 133.

²⁰ Data from countries in sub-Saharan Africa indicate that the proportion of HIV-infected pregnant women receiving ARVs in 2005 varied from under 1% to 54% and that the average regional coverage rate was 11%. In East, South, and Southeast Asia, the average regional coverage rate was 5%, with individual country rates ranging from 3% to 10%. On average, in Latin America and the Caribbean, 24% of HIV-infected mothers had access to ARVs; the coverage rate ranged from 13% to 46%. It is estimated that overall coverage amounted to 75% in Eastern Europe and Central Asia with coverage rates ranging from 38% to 95%. ARV coverage for HIV-infected pregnant women in North Africa and the Middle East averaged less than 1%.

²¹ "Early Marriage and HIV Risks in Sub-Saharan Africa." *Studies in Family Planning*, Vol. 35, No. 3, September 2004. <http://www.blackwell-synergy.com/links/doi/10.1111/j.1728-4465.2004.00019.x/pdf?cookieSet=1>, "Protecting Young Women from HIV/AIDS: The Case Against Child and Adolescent Marriage." *International Family Planning Perspectives*, Vol. 32, No. 2, June 2006. <http://www.jstor.org/journals/01622749.html>.

girls' partners were found to carry HIV, while 16.8% of unmarried girls' boyfriends were HIV-positive.²² Societal forces also weaken women's options, rights advocates contend, because in many countries, health workers require women to obtain their husbands' permission before providing them contraception.²³

Expand Access to Condoms

Global health activists also insist that OGAC's policy of limiting condom distribution to "high risk groups"²⁴ ignores gender inequities and limits the effectiveness of prevention programs. U.S. condom distribution strategies do not include married women, unless their husbands test positive for HIV. Supporters of U.S. condom distribution guidelines counter that the definition of "high risk" individuals is broad enough to include the most vulnerable groups. Some HIV/AIDS proponents advocate that Congress expand the definition of "high risk" individuals to include married young people. Advocates hope that an expanded definition might enable young married people to access condoms through U.S.-supported programs.

Explore the Potential Impact of Circumcision

Health experts have begun to debate the role that circumcision could play in HIV prevention efforts. Three randomized trials conducted in South Africa, Kenya, and Uganda demonstrated that male circumcision reduced the risk of acquiring HIV by more than half. Some believe that if mass circumcision was to be conducted in areas of high transmission, the procedure could avert about 5.7 million new HIV infections and 3 million deaths over 20 years among both men and women.²⁵ WHO and UNAIDS have endorsed the practice to be added to HIV prevention initiatives.²⁶ The organizations warn, however, that the practice should not be seen as a "magic bullet," as it does not prevent men from acquiring the virus, it only reduces the risk of infection. As a result, health experts urge those who perform the surgeries to counsel the men and explain that they must maintain other protective practices, such as abstaining from sex, reducing their number of sexual partners, and using condoms.

Some observers argue that the studies should not yet be widely embraced, particularly since only a few trials have been conducted. A number of scientists question the validity of the studies since they were terminated early; a practice, critics contend, that skews the results.²⁷ Dissenters argue that there may be other explanations for the drop in transmission. Skeptics contend that circumcision reduces the incidence of genital symptoms, allowing men to receive fewer unsafe injections and other blood exposures during treatment. Also, in sub-Saharan Africa, circumcised virgins and adolescents are reportedly more likely to be HIV-infected than their uncircumcised

²² *The Implications of Early Marriage for HIV/AIDS Policy*. Population Council, 2004. <http://www.popcouncil.org/pdfs/CM.pdf>.

²³ *Violence Against Girls and Women: Effects on Sexual and Reproductive Health Decision Making*. UNFPA website, accessed on May 14, 2007 <http://www.unfpa.org/intercenter/violence/effects2a.htm>.

²⁴ High risk groups are defined as sex workers and their clients; sexually active discordant couples (when one partner is HIV-positive and the other is not infected) or couples with unknown HIV status; substance abusers; mobile male populations; men who have sex with men; and people living with HIV/AIDS.

²⁵ "Circumcision and Circumspection." *The Lancet Infectious Diseases*, May 2007, Vol. 7, No. 5, <http://www.thelancet.com/journals/laninf/article/PIIS1473309907700877>.

²⁶ WHO, "WHO and UNAIDS announce recommendations from expert consultation on male circumcision for HIV prevention." March 28, 2007. <http://www.who.int/hiv/mediacentre/news68/en/index.html>.

²⁷ "Male Circumcision in HIV Prevention." *The Lancet*, Vol. 369, No. 9573, May 12, 2007, <http://www.thelancet.com/journals/lancet/article/PIIS0140673607607375>.

counterparts. Researchers suspect that unhygienic circumcision procedures might be a large factor in this phenomenon.²⁸

Critics and advocates of the practice agree that additional studies need to be conducted and a number of precautions must be taken should the practice be implemented on a larger scale.²⁹ Additional research is needed to determine how the procedure might impact HIV transmission to women, the most affected population in Africa. There is consensus that male circumcision must be considered part of a comprehensive HIV prevention package, which includes treatment for sexually transmitted infections; the promotion of safer sex practices; and the provision of male and female condoms and promotion of their correct and consistent use. HIV/AIDS advocates maintain that men and their sexual partners must also be counseled to prevent them from developing a false sense of security and engaging in high-risk behaviors that could undermine the partial protection provided by male circumcision. Health experts agree that African health systems need to be strengthened in order to ensure safe and clean operations. Circumcision must be done under hygienic conditions by trained personnel with access to sterile surgical instruments and anaesthesia. Many facilities on the continent, however, lack sufficient supplies, such as gloves, clean needles, and antiseptics. Some health experts fear that greater investment in circumcision might disrupt other health care programs. Global health advocates urge Congress to ensure that male circumcision services are integrated with other services, particularly in areas with severe shortages of skilled health workers, should it include support for the practice in PEPFAR.

Reconsider Spending Restrictions and Requirements

Evaluate the Impact of the Prostitution Pledge

A number of global health experts contend that some current U.S. AIDS-related spending restrictions and requirements are ideologically based, negatively impact the effectiveness of PEPFAR programs, and complicate implementing partners' efforts. The U.S. Leadership Against HIV/AIDS, TB, and Malaria Act (P.L. 108-25) mandates that no funds made available to carry out the act may be used to assist any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking. This policy has become widely known as "the prostitution pledge." Critics of the pledge contend that the restriction should be eliminated, because it limits implementing partners' HIV/AIDS prevention efforts.³⁰ Opponents argue that

²⁸ "Male Circumcision in HIV Prevention." *The Lancet*, Vol. 369, No. 9573, May 12, 2007, <http://www.thelancet.com/journals/lancet/article/PIIS0140673607607351>.

²⁹ UNAIDS, *Male Circumcision: Context, Criteria, and Culture*. http://www.unaids.org/en/mediacentre/pressmaterials/featurestory/20070226_MC_pt1.asp.

³⁰ USAID's policy directive on the prostitution pledge can be found at http://www.usaid.gov/business/business_opportunities/cib/pdf/aapd05_04.pdf. Criticisms of PEPFAR spending requirements include AIDS Taskforce of Greater Cleveland, *Is PEPFAR Working? A Response to the Recent Annual Report Issued by the President's Emergency Plan for AIDS Relief*, May 2006. <http://www.aidstaskforce.org/ASSETS/72BF3DD44B1E4B93A1077EC95C655E81/PEPFAR.pdf>; Health Gap, *U.S. Global AIDS Initiative, Round 2: From Emergency to Sustainability*, May 29, 2007. <http://www.healthgap.org/PEPFAR-Renewal.doc>; Center for Health and Gender Equity Policy Brief, *Implications of U.S. Policy Restrictions for Programs Aimed at Commercial Sex Workers and Victims of Trafficking Worldwide*, November 2005. <http://www.genderhealth.org/pubs/ProstitutionOathImplications.pdf>; "The US Anti-Prostitution Pledge: First Amendment Challenges and Public Health Priorities." *PLoS Medicine*, Vol. 4, No. 7, <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0040207&ct=1>; Advocates for Youth, *Improving U.S. Global AIDS Policy for Young People*, 2007, <http://www.advocatesforyouth.org/publications/pepfar.pdf>; and Open Society Institute, "Anti-Prostitution" Materials, June 2007 http://www.soros.org/initiatives/health/focus/sharp/articles_publications/

groups serving sex workers fear that by signing the pledge and openly opposing prostitution, they may isolate the very group that they are attempting to help.

Evaluate the Impact of the Mexico City Policy

The “Mexico City Policy”³¹ has also come under considerable scrutiny. The policy prohibits reproductive health organizations from providing information about abortion. Critics contend that, in some countries, this policy has had devastating effects, because reproductive health services is the only form of health care that many women receive. The House and Senate included language in their reports (H.Rept. 110-197 and S.Rept. 110-128) for FY2008 Foreign Operations appropriations (H.R. 2764) that prevented the “Mexico City Policy” from being the sole reason that U.S. funds could not be used to provide contraceptives. A conference is pending. Opposing Members expect the President to veto any bill that repeals the “Mexico City Policy.”

Evaluate the Impact of the Abstinence-Until-Marriage Stipulation

Some health experts assert that congressional HIV prevention stipulations are not well-balanced, place too much emphasis on abstinence until marriage, and limit countries’ ability to use prevention funds in a manner that is most relevant to local conditions. P.L. 108-25, which delineates how PEPFAR funds should be allocated, stipulates that between FY2006 and FY2008, 20% of global HIV/AIDS funds are to be used for prevention efforts, of which at least 33% should be expended for abstinence-until-marriage programs. In 2006, the Government Accountability Office (GAO) found that PEPFAR’s spending requirements limited the flexibility with which prevention funds could be spent.³² GAO estimated that in order to meet the 33% proviso, between FY2004 and FY2006, OGAC increased spending on prevention by almost 55% and mandated that country teams spend half of prevention funds on sexual transmission prevention and two-thirds of those funds on abstinence/faithfulness (AB) activities. In its congressionally mandated report, the Institute of Medicine (IOM) reached similar conclusions.³³

Some health specialists argue that these policies consume limited resources and time, as they place additional reporting requirements on implementing partners. Britain’s Department for International Development (DFID) reports that from 2003 to 2004 and 2006 to 2007, the Ugandan government was reporting on 684 different aid instruments and associated agreements.³⁴ Critics suggest that if Congress reauthorizes PEPFAR, it should eliminate these spending restrictions, coordinate reporting requirements and funding processes with other donors, and urge the United States to sign on to the International Health Partnership. Some in Congress have

publications/pledge_20070612.

³¹ The “Mexico City” policy denies U.S. funds to foreign non-governmental organizations (NGOs) that perform or promote abortion as a method of family planning, even if the activities are undertaken with non-U.S. funds. For more information on the policy, see CRS Report RL33250, *International Population Assistance and Family Planning Programs: Issues for Congress*, by Luisa Blanchfield.

³² GAO, *Spending Requirement Presents Challenges for Allocating Prevention Funding Under the President’s Emergency Plan for AIDS Relief*, April 2006, at <http://www.gao.gov/new.items/d06395.pdf>.

³³ Section 101 (c)(1) of P.L. 108-25 mandated that not later than three years after its enactment, the Institute of Medicine (IOM) would “publish findings comparing the success rates of the various programs and methods used under the [PEPFAR] strategy.” In March 2007, IOM released, *PEPFAR Implementation: Progress and Promise*. IOM concluded that “PEPFAR has made a promising start, but the need for U.S. leadership in the effort to control the HIV/AIDS pandemic continues.”

³⁴ DFID, *Millennium Development Goals: Health Facts and Figures* http://www.dfid.gov.uk/mdg/health-facts-figures.asp#The_donor_coordination_challenge.

supported legislation that was introduced to remove the spending provisions. The HIV Prevention Act (S. 1553) and the Protection Against Transmission of HIV for Women and Youth Act (H.R. 1713) would strike the 33% abstinence-until-marriage spending requirement from P.L. 108-25. The FY2008 House Foreign Operations Appropriations would allow the Administration to determine whether to apply the 33% abstinence-until-marriage provision to global HIV/AIDS programs.

Expand Access to Generic Anti-Retroviral Medication

Access to generic HIV/AIDS treatments is another possible issue to arise in reauthorization debates. Shortly after PEPFAR was launched, the Bush Administration expressed skepticism about broad-based use of generic ARV medication. The Administration asserted that WHO's prequalification process was inadequate, and that generic drugs purchased with PEPFAR funds had to be first inspected by the U.S. Food and Drug Administration (FDA).³⁵ The Administration argued that since WHO is not a regulatory body, its adherence to stringent FDA standards could not be ensured.³⁶ This policy sparked a debate with critics contending that the process was unnecessary and delayed the distribution of ARVs.³⁷ In January 2005, GAO reported that the policy limited the selection of ARV products available, did not fully support the treatment strategies of the focus countries, and was not optimally coordinated with other multinational initiatives. GAO indicated that "better coordination with the Focus Countries and with other treatment initiatives could facilitate more rapid implementation of the Emergency Plan. Moreover, given the intended scale of the plan, lower prices for ARVs could result in savings of hundreds of millions of dollars, which could be used to treat additional patients or to support other aspects of the program."³⁸

In March 2007, IOM found that in many of the Focus Countries, a number of those implementing HIV/AIDS programs complained that the U.S. treatment policy complicated national treatment efforts.³⁹ The Institute recommended that OGAC work to support WHO prequalification as the accepted global standard for assuring the quality of generic medications and work with other donors to support strengthening the process. According to OGAC's third annual report to Congress, OGAC has strengthened its coordination with WHO, by sharing information on the WHO-approved generics. OGAC estimates that in FY2006, 27% of all ARVs purchased under PEPFAR were generic.⁴⁰ Since FDA began reviewing generic drug applications, more than 50

³⁵ The WHO prequalifying process includes an assessment of product files (lasting approximately two to four months); site inspections; and the procurement of data on all active pharmaceutical ingredients, specifications, product formulas, and manufacturing methods. After the products and manufacturing sites meet the required standards, the medicine is added to the list of prequalified products. For more information, see <http://www.who.int/3by5/publications/briefs/amds/en/>.

³⁶ Interviews with staff at the Office of the AIDS Coordinator, April 1, 2004.

³⁷ David Brown and Ellen Nakashima, "U.S. Rule on AIDS Drugs Criticized," *Washington Post*, July 14, 2004; Steve Sternberg, "Bush's AIDS Plan Could be Tough to Implement," *USA Today*, July 14, 2004; and "The end of the beginning? AIDS," *The Economist*, July 17, 2004. For more on the debate about the FDA review process, see the KaiserNetwork website at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=27788.

³⁸ GAO, *Global HIV/AIDS Epidemic: Selection of Antiretroviral Medications Provided Under U.S. Emergency Plan Is Limited*, January 2005. <http://www.gao.gov/new.items/d05133.pdf>.

³⁹ <http://www.iom.edu/CMS/3783/24770/41804.aspx>.

⁴⁰ OGAC, *The Power of Partnerships: The President's Emergency Plan for AIDS Relief*, 2007. <http://www.pepfar.gov/documents/organization/81019.pdf>.

generic versions of patented ARVs have been approved or tentatively approved for use in PEPFAR treatment plans.⁴¹

Improve Integration of Health Programs

In considering whether to extend PEPFAR, HIV/AIDS experts encourage Congress to stipulate stronger integration of PEPFAR-supported programs with other health programs that save lives. Many health experts contend that PEPFAR's disease-specific approach threatens to supplant support by the United States and recipient countries for other health areas, including nutrition, maternal and child health, and other infectious diseases.

Improve Food Security

Malnutrition and lack of food may heighten exposure to HIV, raise the likelihood of engaging in risky behavior (e.g., transactional sex), increase susceptibility to infection, and complicate efforts to provide anti-retroviral (ARV) medication. Furthermore, those sickened by HIV/AIDS are often too ill to till the land, lessening agricultural productivity. The United Nations' Food and Agriculture Organization (FAO) estimates that food consumption drops by 40% in homes affected by HIV/AIDS, due in large part to diminished capacity to farm.⁴²

In communities struggling with food security, decreased food production can complicate efforts to maintain treatment regimens. If patients do not consume adequate amounts of nutritious food, they can suffer significant side effects while taking ARVs and the drugs can be less effective. At the 2006 International AIDS Conference, one AIDS advocate cited a study that showed that patients who were malnourished when they started ARV therapy were six times more likely to die than well-nourished patients, and were more likely to suffer side-effects, which often caused them to stop taking the treatments.⁴³ These issues are particularly acute in rural communities, where AIDS incidence is rapidly increasing and access to care is usually more limited than in urban areas. In the 25 most AIDS-affected countries in Africa, more than 2/3 of the population live in rural areas and rely on agriculture for their livelihoods.⁴⁴

In April 2007, the House Foreign Affairs Committee held a hearing on the progress of PEPFAR. At the hearing, Global AIDS Coordinator Mark Dybul testified that PEPFAR funds provided "limited food assistance for specific, highly vulnerable populations," and cited support for a pilot program that enables a local food manufacturer to distribute nutrient-dense food to orphans and vulnerable children, clinically malnourished HIV-positive people, and HIV-positive pregnant and lactating women enrolled in PMTCT programs. He also indicated that in FY2006, OGAC had contributed \$2.45 million contribution to the World Food Program (WFP) and would contribute an additional \$4.27 million in FY2007. Ambassador Dybul conceded that PEPFAR's engagement in food insecurity is limited. He contended, however, that efforts are intentionally limited, because OGAC prefers to remain focused on HIV/AIDS. At the hearing, Ambassador Dybul

⁴¹ PEPFAR website, *FDA Grants Tentative Approval for 50th and 51st Anti-Retroviral Drugs Under President's AIDS Relief Plan*, August 13, 2007. <http://www.pepfar.gov/press/91018.htm>. For more information on FDA's role in reviewing ARVs, see <http://www.fda.gov/oia/pepfar.htm>.

⁴² FAO factsheet, *HIV/AIDS, food security, and rural livelihoods* <http://www.fao.org/worldfoodsummit/english/fsheets/aids.pdf>.

⁴³ Statement made by Stuart Gillespie at the 2006 International AIDS Conference, *"Breaking the Vicious Cycle of HIV/AIDS and Hunger."* <http://www.ifpri.org/PRESSREL/2006/20060813.asp>.

⁴⁴ FAO, *The Impact of HIV/AIDS on Agriculture and Food Security*, 2003, <http://www.fao.org/docrep/005/Y8331E/Y8331E00.htm>.

testified that PEPFAR supports other “wrap around” programs that support HIV-affected populations, such as clean water programs, education initiatives, and gender projects.

Support Maternal and Child Health

According to the United Nations, maternal and neonatal⁴⁵ mortality rates could be significantly reduced if more women, particularly in Africa, had sufficient access to skilled health personnel who are trained to detect problems early and can effectively provide or refer women to emergency obstetric care. The United Nations has found that regions with the lowest proportions of skilled health attendants at birth also have the highest number of maternal deaths.⁴⁶ In sub-Saharan Africa, 1 of every 16 women who becomes pregnant will die from complications arising during her pregnancy or childbirth. For comparison, the rate in industrialized countries is one in 3,800.⁴⁷ Experts have also found that child survival rates are higher in areas with ample numbers of health workers to administer immunizations, clean water, controlled mosquito populations, and sufficient access to nutritious food.⁴⁸

Address Other Diseases That Kill

Those who support integrating PEPFAR into other health programs contend that disease-specific programs like PEPFAR fail to address adequately the intersection of diseases.⁴⁹ Research has demonstrated that since HIV weakens the immune systems of those infected, they are more susceptible to a range of illness, including malaria. HIV-positive people are more likely to be hospitalized and sickened by malaria than those not carrying the virus. According to WHO, Africa is the only region in the world where incidence of new TB infections continues to rise, due in large part to HIV/AIDS co-infection.⁵⁰ In 2004, more than 740,000 people who contracted TB were co-infected with HIV/AIDS.⁵¹ Some 600,000 of those co-infected with TB and HIV/AIDS

⁴⁵ Neonatal refers to the first four weeks of life.

⁴⁶ United Nations, *The Millennium Development Goals Report: 2007*, <http://www.un.org/millenniumgoals/pdf/mdg2007.pdf>. While the greatest shortage of health care workers in absolute terms are in southeast Asia (mostly in Bangladesh, India, and Indonesia), sub-Saharan Africa suffers from the greatest proportional shortage of health care workers in the world. WHO estimates that there are 57 countries with critical shortages of health care workers, 36 of which are in Africa and none of which are in industrialized nations. Globally, WHO estimates that an additional 4.3 million health workers are needed, and that Africa would need to increase its number of health workers by about 140% in order to meet the minimum threshold of 2.5 health care professionals per 1,000 people. WHO, *2006 World Health Report*, <http://www.who.int/whr/2006/en/>.

⁴⁷ United Nations, *Africa and the Millennium Development Goals: 2007 Update*, <http://www.un.org/millenniumgoals/docs/MDGafrica07.pdf>.

⁴⁸ Laurie Garrett, “*The Challenge of Global Health*,” *Foreign Affairs*, New York: January/February 2007, Vol. 86, Issue 1, <http://www.foreignaffairs.org/20070101faessay86103/laurie-garrett/the-challenge-of-global-health.html>.

⁴⁹ See UNAIDS, *2006 AIDS Epidemic Update*, and CDC, *Interaction of HIV and Malaria*, http://www.cdc.gov/malaria/pdf/Malaria_HIV_Rick_website.pdf.

⁵⁰ WHO, *2006 Global Tuberculosis Control Report*, http://www.who.int/tb/publications/global_report/2006/en/. People living with HIV/AIDS are at greater risk of becoming infected with TB because of their weakened immunity. Each disease speeds up the progress of the other, and TB considerably shortens the survival of people with HIV/AIDS. HIV/AIDS is the most potent risk factor for converting latent TB into active TB, while TB bacteria accelerate the progress of AIDS. Many people affected by HIV/AIDS in developing countries develop TB as the first manifestation of AIDS. In HIV/AIDS-positive people, TB is harder to diagnose, progresses faster, is almost always fatal if undiagnosed or left untreated, and kills up to half of all AIDS patients worldwide. People with HIV/AIDS are up to 50 times more likely to develop TB in a given year than HIV/AIDS-negative people. About 90% of people living with AIDS die within four to twelve months of contracting TB if not treated.

⁵¹ Information in this paragraph summarized from WHO, *2006 Global Tuberculosis Control Report*, http://www.who.int/tb/publications/global_report/2006/en/.

were found in sub-Saharan Africa, representing more than 80% of all co-infected cases. About 205,000 of the more than 248,000 co-infected patients who died from TB were African, representing 83% of those deaths. Most poorly equipped health systems in Africa are unable to contain TB, as they have limited case detection capacity; meager financing; too few health workers in numbers and who are sufficiently trained; inconsistent drug supplies; and little means to monitor and evaluate TB control programs.

Strengthen Health Systems

PEPFAR critics urge Congress to consider not only the degree to which resources are skewed towards HIV/AIDS initiatives, but also what impact such unbalanced spending has on health systems overall. Many global health experts maintain that the generous salaries and other incentives (such as housing stipends) offered by donor-supported HIV/AIDS programs draw health workers from public health facilities and threaten other life-saving interventions offered at those clinics, such as maternal and child survival health initiatives.⁵²

Address Health Worker Shortages

According to WHO, the global shortage of health care workers is the single most important health issue facing countries today.⁵³ While the greatest shortages of health care workers in absolute terms are in southeast Asia (mostly in Bangladesh, India, and Indonesia), sub-Saharan Africa suffers from the greatest proportional shortage of health care workers in the world (**Table 4**). WHO estimates that there are 57 countries with critical shortages of health care workers; 36 are in Africa and none are in industrialized nations. Globally, WHO estimates that an additional 4.3 million health workers are needed, and that Africa would need to increase its number of health workers by about 140% in order to meet the minimum threshold. None of the countries in **Table 5** have enough doctors to meet the most basic health care needs; though when nurses and midwives are included, some do meet the minimum standard. The amount and quality of health worker numbers are positively associated with immunization coverage, outreach of primary care, as well as infant, child, and maternal survival.

After the release of the World Bank's report, *International Migration, Remittances, and the Brain Drain*, a number of articles in the press featured the issue, and highlighted some of the data provided in the work.⁵⁴ It is estimated that 20,000 skilled professionals leave Africa each year.⁵⁵ Erik Schouten, the HIV Coordinator for the Malawi Ministry of Health announced that over the last five years, the government had lost 53% of its health administrators, 64% of its nurses, and 85% of its physicians—mostly to foreign NGOs, largely funded by Britain, the United States, and the Gates Foundation.⁵⁶ According to Mr. Schouten, the Ministry is now implementing a program,

⁵² Child mortality refers to the death of children younger than five years, <http://www.who.int/healthinfo/statistics/mortchildmortality/en/index.html>. "The Challenge of Global Health," *Foreign Affairs*, January/February 2007, Vol. 86, Issue 1, <http://www.foreignaffairs.org/20070101faessay86103/laurie-garrett/the-challenge-of-global-health.html>. "Lack of money can no longer be blamed for the poor world's health problems," *The Economist*, July 5, 2007.

http://www.economist.com/world/international/displaystory.cfm?story_id=9441391.

⁵³ WHO, *2006 World Health Report: Working Together for Health*, <http://www.who.int/whr/2006/en/>. The Joint Learning Initiative (JLI), a network of global health leaders, defines a shortage as less than 2.5 health care professionals per 1,000 people; the minimum proportion it deemed necessary to provide 80% of a country's population with basic health care (e.g., deliveries by skilled birth attendants and immunizations).

⁵⁴ <http://www.worldbank.org>.

⁵⁵ "Brain drain deprives Africa of vital talent." Reuters, April 24, 2006 <http://www.alertnet.org>.

⁵⁶ "The Challenge of Global Health," *Foreign Affairs*, January/February 2007, Vol. 86, Issue 1 <http://www.foreignaffairs.org/20070101faessay86103/laurie-garrett/the-challenge-of-global-health.html>.

supported by PEPFAR, to attract Malawi health workers back to the country. Their tasks, however, will be to distribute antiretroviral medication. There is reportedly no support for programs to attract health workers to treat malaria, diarrhea, and other common killers, such as dysentery and respiratory infections.

Table 4. Number and Shortage of Doctors, Nurses, and Midwives

WHO Region	Number of Countries		In Countries with Shortages		
	Total	With Shortages	Total Workforce	Estimated Shortage	Increase Required
Africa	46	36	590,198	817,992	139%
Americas	35	5	93,603	37,886	40%
Southeast Asia	11	6	2,332,054	1,164,001	50%
Europe	52	0	not applicable	not applicable	not applicable
Eastern Mediterranean	21	7	312,613	306,031	98%
Western Pacific	27	3	27,260	32,560	119%
World	192	57	3,355,728	2,358,470	70%

Source: WHO, 2006 World Health Report.

Table 5. Distribution of Health Workers in Africa and the United States

Country	Population (2005)	Physicians		Nurses		Midwives		Year Data Collected
		Number	Number per 1,000	Number	Number per 1,000	Number	Number per 1,000	
Angola	15,941,000	881	0.08	13,135	1.15	492	0.04	1997
Cameroon	16,322,000	3,124	0.19	26,042	1.60	45	0.00	2004
Ethiopia	77,431,000	1,936	0.03	14,893	0.21	1,274	0.02	2003
Ghana	22,113,000	3,240	0.15	19,707	0.92	3,910	0.18	2004
Mozambique	19,792,000	514	0.03	3,954	0.21	2,236	0.12	2004
Nigeria	131,530,000	34,923	0.28	210,306	1.70	6,344	0.05	2003
South Africa	47,432,000	34,829	0.77	184,459	4.08	82,726	0.67	2003
Uganda	28,816,000	2,209	0.08	16,221	0.61	4,164	0.16	2004
Tanzania	38,329,000	822	0.02	13,292	0.37	not available		2002
Zimbabwe	13,010,000	2,086	0.16	9,357	0.72	not available		2004
Africa Total	738,086,000	150,561	0.22	663,572	0.96	125,142	0.25	variable
United States	295,410,000	730,801	2.56	2,669,603	9.37	not available		2000

Source: WHO, 2006 World Health Report.

Consider the Impact of Disease-Specific Approach on Health Systems

Ambassador Dybul asserted at the April 2007 House hearing that PEPFAR strengthens health systems and expands the health workforce. This assertion counters the findings that the Institute of Medicine published in its March 2007 report, *PEPFAR Implementation: Progress and Promise*.⁵⁷ Though IOM concluded that “PEPFAR has made a promising start,” it found PEPFAR might further limit health care options for those not suffering from HIV/AIDS.

PEPFAR’s HIV/AIDS activities have sometimes negatively affected other aspects of public health systems and exacerbated resource constraints, particularly those related to national human resource settings. If Focus Countries’ national plans for expanding their health workforce are not supported, PEPFAR might worsen national shortages by shifting a disproportionate share of the workforce to HIV/AIDS activities, which might cause other health areas to be neglected.... PEPFAR’s initial emergency approach to meeting personnel needs has been to focus on HIV-specific training of existing clinicians and other health care workers. Support for expansion of the professional clinical workforce has been limited, even when such expansion is an explicit part of the country’s HIV/AIDS plan, and the effort is endorsed and supported by other donors... PEPFAR Country Teams often expressed concern that they were not allowed to fund activities unless those activities were specifically part of the HIV/AIDS effort and so could not support, for example, the training of new clinical officers, who in some countries are the mainstay of the treatment efforts.⁵⁸

IOM recommended that OGAC work more closely with governments to analyze the impact that PEPFAR-supported programs might have on public health systems, particularly in areas related to maternal and child health and immunizations. IOM suggested that the analysis consider whether PEPFAR’s incentives and salaries draw workers out of public systems and shift a disproportionate share of the workforce to HIV/AIDS efforts. The report also asserted that PEPFAR should increase support to the education of new health professionals.

Support Global Efforts to Strengthen Health Systems

There is a growing consensus that health systems, including those that address HIV/AIDS, must be strengthened in order for health interventions to be effective. On August 22, 2007, British Prime Minister Gordon Brown and German Chancellor Angela Merkel announced their intention to launch an International Health Partnership (IHP) aimed at accelerating progress towards reducing child and maternal mortality, combating infectious diseases, including HIV/AIDS, TB, and malaria, and strengthening health systems.⁵⁹ The leaders acknowledged in their statement that the fragmented method of applying global health aid has reduced the effectiveness of aid, in large part because donors compete for limited trained staff and implement the projects without considering the countries’ priorities and structures.⁶⁰ According to DFID, there are more than 40 bilateral donors and 90 global health initiatives each maintaining their own reporting requirements and most focusing on specific health issues, such as HIV/AIDS.⁶¹ DFID asserts that few global health efforts focus on activities that would strengthen struggling health systems, such

⁵⁷ <http://www.iom.edu/CMS/3783/24770/41804.aspx>.

⁵⁸ Ibid.

⁵⁹ 10 Downing Street, *PM announces International Health Partnership*, August 22, 2007, <http://www.number-10.gov.uk/output/Page12903.asp>.

⁶⁰ Ibid.

⁶¹ DFID, *The International Health Partnership Launched Today*, September 5, 2007, <http://www.dfid.gov.uk/news/files/ihp/default.asp>.

as training doctors and nurses, building clinics, or supporting basic health services. Parties⁶² of the IHP commit to improving donor coordination, focusing on health systems rather than specific diseases or health issues, and supporting the health plans of recipient countries. The leaders did not indicate how much would be allocated towards this initiative or how it would be implemented, though seven countries were identified as “first wave” partner countries.⁶³

Provide Support for Health Systems Research

Some health experts would like Congress to boost support for health systems research if it were to extend PEPFAR.⁶⁴ The Global Health Council estimates that less than 1% of research dollars are spent on health systems research, though it could identify where health systems failures exist, make health interventions more effective and affordable, and improve the accessibility of health care.⁶⁵ In HIV/AIDS programs, health systems research could help administrators develop effective forecasting and distribution systems for drugs and other commodities and make stock-outs and shortages of contraceptives, ARVs, and other commodities less frequent. Advocates assert that health systems research could improve retention of health personnel, because they would have sufficient tools to perform their jobs. Data from health systems research would reveal which sort of care, prevention, and treatment programs are needed for the target population, and which would make the programs more effective and efficient, proponents contend.

Consider Role of International Financial Institutions

Some have argued that structural adjustment programs mandated by international financial institutions have led to a decline in public sector employment and limited investment in health worker education.⁶⁶ In many of the countries with health worker shortages, there are thousands of unemployed health workers. While Kenya has a shortage of some 10,000 nurses in the public sector, for example, thousands of unemployed nurses are leaving for Britain to find jobs, as the Kenyan government is under a recruitment freeze due to World Bank and International Monetary Fund (IMF) stipulations.⁶⁷ Health sector reform, critics argue, has led to a decline in the quality of education and training opportunities for medical students, a perpetual shortage of health supplies and equipment (e.g., sanitation gloves and hyperdermic needles), insufficient medicine and

⁶² Bilateral donors include Britain, Canada, France, Germany, Italy, the Netherlands, Norway, and Portugal. Foundations and international organizations include Africa Development Bank, Bill and Melinda Gates Foundation, European Commission, The Global Fund to Fight AIDS, TB, and Malaria, the Global Alliance for Vaccines and Immunization (GAVI) Alliance, UNAIDS, UNICEF, United Nations Population Fund (UNFPA), WHO, and the World Bank.

⁶³ The seven countries are Burundi, Cambodia, Ethiopia, Kenya, Mozambique, Nepal, and Zambia.

⁶⁴ “Health systems” encompasses the personnel, institutions, commodities, information, and the financing of health care delivery.

⁶⁵ Global Health Council, *Promoting Investments in Research to Strengthen Health Systems: Why and How*, May 2006 http://www.globalhealth.org/images/pdf/publications/research_investments.pdf.

⁶⁶ For debate on this issue, see “A Critical Analysis of the Brazilian Response to HIV/AIDS: Lessons Learned for Controlling and Mitigating the Epidemic in Developing Countries,” *American Journal of Public Health*, July 2005, Vol. 95, No. 7,

<http://www.ajph.org/cgi/reprint/95/7/1162.pdf>; “Toward Ethical Review of Health System Transformations,” *American Journal of Public Health*, March 2006, Vol. 96, No. 3, <http://www.ajph.org/cgi/content/abstract/96/3/447>; and Center for Global Development, *Does the IMF Constrain Health Spending in Poor Countries*, June 2007, <http://www.cgdev.org/content/publications/detail/14103/>.

⁶⁷ “Nurse Exodus Leaves Kenya in Crisis,” *The Guardian Unlimited*, May 21, 2006. <http://www.guardian.co.uk/kenya/story/0,,1779821,00.html>.

vaccine stocks, and “brain drain” of African health workers. According to WHO, on average each year, the 57 countries with severe shortages of health workers spend an average of about \$33 per person on health (**Table 6**). The entire continent of Africa spends about 1% of the world’s expenditure on health, the WHO contends. Comparatively, each year the United States spends approximately \$5,711 per capita on health.

Some analysts have expressed concern about the extent to which countries rely on the World Bank to fund their health programs. The Bank estimates that it has lent \$15 billion in health, nutrition, and population funds from 1997 to 2006; an average of about \$1.5 billion per year.⁶⁸ Observers worry that the loans add to significant debt loads that many countries already face and to which they commit considerable portions of their annual gross national products.⁶⁹ In some countries, governments are reportedly paying more on debt service than public health programs. Oxfam estimates that of the 26 countries participating in the Highly Indebted Poor Countries (HIPC) Initiative, half are still spending 15% or more of government revenues on debt payments.⁷⁰ Some health advocates urge Congress to use its vote to encourage the IMF to maintain its debt relief commitments and accelerate its plans.

In the 110th Congress, legislation has been introduced in the House and Senate that authorizes additional funds to voluntary family planning activities, improves coordination of HIV/AIDS and other health initiatives, and strengthens supply chain logistics. The Focus on Family Health Worldwide Act (H.R. 1225) would provide funds to expand access to voluntary family planning programs in developing countries. The U.S. Commitment to Child Survival Act (S. 1418) would provide assistance to improve the health of newborns, children, and mothers in developing countries. The African Health Capacity Investment Act (S. 805) would amend the Foreign Assistance Act of 1961 to assist countries in sub-Saharan Africa achieve internationally recognized goals in the treatment and prevention of HIV/AIDS and other major diseases, reduce maternal and child mortality, improve human health care capacity, and improve the retention of medical health professionals.

Table 6. Spending on Health in Africa and the United States

Country	Population (000)	Per Capita Expenditure on Health	Per Capita Government Expenditure on Health	Total Expenditure on Health as % of GDP	General Government Expenditure as % of Total Government Expenditure	External Resources for Health as % of Total Expenditure on Health
Angola	15,490	\$26.0	\$41.0	2.8%	5.3%	6.7%
Cameroon	16,038	\$37.0	\$19.0	4.2%	8.0%	3.2%
Ethiopia	75,600	\$5.0	\$12.0	5.9%	9.6%	26.0%
Ghana	21,664	\$16.0	\$31.0	4.5%	5.0%	15.8%
Mozambique	19,424	\$12.0	\$28.0	4.7%	10.9%	40.8%
Nigeria	128,709	\$22.0	\$13.0	5.0%	3.2%	5.3%

⁶⁸ World Bank, *Health Development: The World Bank Strategy for Health, Nutrition, and Population Results*. April 2007. <http://www.worldbank.org>.

⁶⁹ “The Global HIV/AIDS Pandemic, Structural Inequalities, and the Politics of International Health,” *American Journal of Public Health*, March 2002, Vol. 92, No. 3, <http://www.ajph.org/cgi/reprint/92/3/343.pdf>.

⁷⁰ Oxfam, *Debt Relief and the HIV/AIDS Crisis in Africa: Does the Heavily Indebted Poor Countries (HIPC) Initiative Go Far Enough?*, June 2002, http://www.oxfam.org/en/files/pp0206_no25_debt_relief_and_the_HIV_crisis.pdf.

Country	Population (000)	Per Capita Expenditure on Health	Per Capita Government Expenditure on Health	Total Expenditure on Health as % of GDP	General Government Expenditure as % of Total Government Expenditure	External Resources for Health as % of Total Expenditure on Health
South Africa	47,208	\$295.0	\$258.0	8.4%	10.2%	0.5%
Uganda	27,821	\$18.0	\$23.0	7.3%	10.7%	28.5%
Tanzania	37,627	\$12.0	\$16.0	4.3%	12.7%	21.9%
Zimbabwe	12,936	\$40.0	\$47.0	7.9%	9.2%	6.8%
United States	295,410	\$5,711.0	\$2,548.0	15.2%	18.5%	0.0%

Source: WHO, 2006 World Health Report.

Note: All figures reflect data collected in 2003, except population, which was collected in 2004.

Address the Needs of Children Affected by HIV/AIDS

UNAIDS estimates that there are 2.5 million children living with HIV around the world, up from 1.5 million in 2001. Nearly 90% of all HIV-positive children live in sub-Saharan Africa. The rate at which children are contracting the virus is declining, however, with 460,000 having acquired HIV in 2001 and 420,000 in 2007. AIDS is also killing fewer children. In 2001, 330,000 children succumbed to the virus; in 2005, 360,000 died from AIDS. But in 2007, the number fell to an estimated 330,000.

HIV/AIDS affects not only those children living with the virus, but also those who lose their parents to the virus and who live in homes that have taken in orphans. Children who have been orphaned by AIDS may be forced to leave school, begin working to supplement lost income, suffer from depression and anger, or engage in survival sex, an activity that heightens their risk of contracting HIV. Children who live in homes that take in orphans may see a decline in the quantity and quality of food, education, love, nurturing, and may be stigmatized. Impoverished children living in households with one or more ill parent are also affected, as health care increasingly absorbs household funds, which frequently leads to the depletion of savings and other resources reserved for education, food, and other basic needs. A number of HIV/AIDS advocates call for increased spending on programs, such as skills building, microcredit lending, daycare subsidization, and education, for caretakers of children orphaned by HIV/AIDS.⁷¹

The U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 authorizes 10% of HIV/AIDS funds to be used to support children affected by the virus. Some of PEPFAR's implementing partners have reportedly suggested that in areas with high HIV/AIDS prevalence, all children should be considered affected by or made vulnerable by HIV/AIDS; and that in high prevalence areas, programs should allow communities to define vulnerability related to their contexts and to identify which children participate in programs.⁷²

⁷¹ For more information on children affected by HIV/AIDS, see CRS Report RL32252, *AIDS Orphans and Vulnerable Children (OVC): Problems, Responses, and Issues for Congress*, by Tiaji Salaam-Blyther.

⁷² Interview with Global Action for Children, a PEPFAR implementing partner, on November 21, 2007.

In the 109th Congress, Congress enacted the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005 (P.L. 109-95), which established a monitoring and evaluation system to measure the effectiveness of related assistance activities; required the Secretary of State to appoint a Special Advisor for Assistance to Orphans and Vulnerable Children within USAID; and required an annual report on project implementation. Congress did not appropriate funds for these activities.⁷³ A number of HIV/AIDS advocates encourage Congress to appropriate funds to make permanent and bolster the power and influence of the Special Advisor. Those who would like for Congress to fund such a permanent position suggest that the advisor would report directly to the Secretary of State and have independent authority to approve and coordinate all U.S. spending on activities related to orphans and vulnerable children.

Supporters of this idea also maintain that the Special Advisor would need appropriations for an office that would be similar in structure to the one at USAID for the President's Malaria Initiative. Proponents contend that the office's staff would: 1) devise a comprehensive U.S. strategy to address the needs of children affected by HIV/AIDS; 2) ensure efficient use of U.S. funds by coordinating all related U.S. programs, including those funded by OGAC, USAID, and other U.S. Departments, international organizations like UNICEF, and public private partnerships; and 3) monitor, evaluate, and submit reports to Congress that detail U.S. spending on related programs. Critics of this idea counter that this position would duplicate and add to the overhead costs of implementing U.S. global HIV/AIDS activities.

According to UNAIDS, more than 2.5 million children and infants are living with HIV/AIDS worldwide, representing more than 7% of all cases; and some 420,000 children under 15 years are expected to contract the virus in 2007, almost 17% of all new HIV infections. OGAC asserts that children have disproportionately low access to HIV treatment and care relative to adult populations in most developing countries. Without treatment and care, approximately 50% of all HIV-positive children will die before age two and 75% will die before age five.⁷⁴ Some advocates for children urge Members to increase spending on pediatric HIV/AIDS ARVs so that funding meets the needs of children without access to treatment. OGAC estimates that in FY2006, it allocated 9% of all spending on ARVs to children.⁷⁵

Reconsider Emphasis on Focus Countries

HIV/AIDS analysts advocate that other countries where the virus is rapidly spreading be included in GHAI. In Eastern Europe and Central Asia, HIV has become more entrenched. According to UNAIDS, the number of people living with HIV in those regions has increased by more than 150% since 2001. An estimated 1.6 million people are living with HIV/AIDS in the region, up from 630,000 in 2001. Nearly 90% of newly reported HIV diagnoses in this region in 2006 were from two countries: the Russian Federation (66%) and Ukraine (21%).

A number of health experts are also concerned about the HIV/AIDS epidemic in the Caribbean. Estimates indicate that prevalence rates have largely stabilized in the region, though they remain high in Haiti and the Dominican Republic.⁷⁶ Nearly 75% of all people living with HIV/AIDS in

⁷³ P.L. 109-95; 22 U.S.C. 2152f note. The act amended the Foreign Assistance Act of 1961 (P.L. 87-195) at Section 135 (22 U.S.C. 2152f) to establish the new program and position.

⁷⁴ Elizabeth Glaser Pediatric AIDS Foundation, "In the Battle Against HIV/AIDS, Equal Treatment for Children," October 19, 2007, <http://www.pedaids.org/News/Publications/Fact%20Sheet/PEPFAR%20Fact%20Sheets.aspx>.

⁷⁵ PEPFAR website, "Pediatric Treatment and Care," June 2007, <http://www.pepfar.gov/pepfar/press/86524.htm>.

⁷⁶ The 2007 *AIDS Epidemic Update* did not provide 2007 prevalence estimates for Haiti and the Dominican Republic. The report did indicate, however, that prevalence appears to have declined in Haiti since 1996. Among pregnant

the Caribbean reside in the two countries. Some 230,000 people are HIV-positive in the Caribbean, of whom 11,000 UNAIDS expect to die from the virus. In February 2007, Representative Luis Fortuño introduced H.R. 848, to Amend the State Department Basic Authorities Act of 1956 to Authorize Assistance to Combat HIV/AIDS in Certain Countries of the Caribbean Region.

Some caution that before Members consider expanding the number of Focus Countries, Congress might first need to determine the extent of its commitment to supporting global HIV/AIDS efforts. A number of HIV/AIDS advocates point out that HIV/AIDS is a chronic disease that requires long-term care. In order for countries to assume ownership of HIV/AIDS initiatives and expand them, this view holds, they must first know how much support to expect from the United States and for how long that support might last.

Glossary of Abbreviations and Acronyms

ARV	Anti-Retroviral medication
DFID	Department for International Development
FAO	United Nations Food and Agriculture Organization
FDA	U.S. Food and Drug Administration
GAO	Government Accountability Office
GHAI	Global HIV/AIDS Initiative
HIPC	Highly Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IHP	International Health Partnership
IMF	International Monetary Fund
IOM	Institute of Medicine
JLI	Joint Learning Institute
MTCT	Mother-to-Child Transmission
NIH	National Institutes of Health
NGO	Non-Governmental Organization
OAR	Office of AIDS Research
OGAC	Office of Global AIDS Coordinator
PEPFAR	President's Emergency Plan For AIDS Relief
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	U.S. Agency for International Development

women attending antenatal clinics, HIV prevalence fell from 5.9% in 1996 to 3.1% in 2004, and appeared to have stabilized in 2006. UNAIDS attributes the declining trend to decreasing infection levels in the capital, Port-au-Prince, and other cities, where HIV prevalence among 15 – 44-year-old women fell from 5.5% to 3% between 2000 and 2005. The report also indicated that prevalence rates appears to have stabilized in Dominican Republic.

WFP	World Food Program
WHO	World Health Organization

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